FAQ: Med Fee Disputes

The following questions concern the rules and regulations governing charges for medical services provided under the Idaho Workers' Compensation Law (IDAPA 17.02.08.031 and IDAPA 17.02.08.032).

The rules and regulations governing charges for medical services under the Idaho Workers' Compensation Law state that, "Payors shall pay a Provider's reasonable charge for medical services furnished to industrially injured patients."

DEFINITIONS

- **What is a reasonable charge for medical services?**

  - A reasonable charge, with certain exceptions, is one that does not exceed the Provider's usual charge and does not exceed the customary charge. (See IDAPA I7.02.08.031.02.d)

- **What is a Provider's usual charge?**

  - A usual charge is the most frequent charge made by an individual Provider for a given service to non-industrially injured patients. (See IDAPA 17.02.08.03].

  - NOTE: When Industrial Commission staff reviews a Provider's Motion* to determine whether a Provider's charge is "usual," the staff looks for evidence that the disputed charge did not exceed that charged by the Provider to non-industrial patients for the same service. A "Non-industrial patient" is one who is not claiming a work-related injury or illness. * See following for a description of the term "Motion."

- **What is a customary charge?**

  - A customary charge is defined as a charge which shall have an upper limit no higher than the 90th percentile of usual charges made by Idaho Providers for a given service. (See IDAPA 1 7.02.08.031.02f)

  - NOTE: The Commission relies on certain data to establish a "customary" charge (the Commission assumes that providers do not have access to information regarding the "customary" charge for a specific service).

  - The data relied upon by the Commission in determining "customary" charges consists of actual charges for medical services made by Idaho providers. As of July 1, 1995, these charges are derived from general liability insurance companies as well as workers' compensation sureties. The Commission's compilation of charges is updated at least once a year.

- The Commission establishes "customary" charges solely for the purpose of resolving medical fee disputes filed with the Commission. It is not intended to be a mandatory fee schedule for services provided to industrially injured patients.

- **What are medical reports as mentioned in the Industrial Commission regulations?**

  - Medical reports are records which have been generated because a patient has been treated. As defined under IDAPA 17.02.04.322.0l.f, "medical report" includes without limitation, all bills, chart notes, surgical records, testing results, treatment records, hospital records, prescriptions and medication records. (See IDAPA 17.02.08.032.03. c.)

  - NOTE: This is not an exclusive list.

- **What are medical services as used in the Industrial Commission regulations? Are pharmaceutical drugs included as a medical service?**

  - **Medical services** include medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicines, apparatus, appliances, prostheses, and related services, facilities, equipment and supplies. (See IDAPA 1 702.08.031.02. c)

    As a form of medicine, pharmaceutical drugs are considered a **medical service** for purposes of the Commission regulations.

- **What is the difference between a Motion for Approval of Disputed Charges and a Motion for Reconsideration and/or to Present Additional Evidence?**

  - A Motion for Approval of Disputed Charges is a formal document (a "Motion") filed with the Commission by a Provider who has received a Payor's Final Objection to disputed charges. After receiving a Motion for Approval of Disputed Charges, Commission staff reviews all documentation that was timely submitted. The Commission will issue an Administrative Order that approves or disapproves, in whole or in part, the disputed charges. The Commission may also dismiss a Motion.

  - A Motion for Reconsideration and/or to Present Additional Evidence is a formal document (a "Motion") filed with the Commission by any party adversely affected by the Administrative Order issued by Commission staff. It is essentially an appeal to the Commission. After receiving a Motion for Reconsideration and/or to Present Additional Evidence, the Commission will determine whether the interests of Justice will be served by further review, and may issue an Order affirming, reversing, or remanding back to staff the previous Administrative Order.

  - NOTE: Both types of Motions are described in detail in the Commission's Judicial Rule Re: Disputes Between Providers and Payors, under IDAPA 17.02.08.031 and IDAPA 17.02.08.032.

BILLINGS

- **Do the medical fee regulations require modifiers to be included on the Provider's bill for CPT coded services?**

    - Effective July 1, 1995, the Commission's regulations require that a Provider's bill describe medical services provided using appropriate Current Procedural Terminology (CPT) coding, *including modifiers*, for the year in which the service was performed. *(See IDAPA 17.02.08.032.03. a)*

    - For appropriate CPT code modifiers and their definitions, a Provider should use the Physicians' Current Procedural Terminology, published by the American Medical Association, for the year in which the service was performed.

- **Do I have to send my medical report at the same time I send my bill for services? What happens if I do not send my report with the bill?**

    - If required by the Payor, a Provider's bill must be accompanied by the corresponding medical report.

    - Where the bill is not accompanied by the report, the timelines requiring prompt payment and the issuance of Preliminary Objections/Requests for Clarification by the Payor do not commence until the report and bill have both been received by the Payor. *(See IDAPA 17.02.08.032.03.c)*

    - A Payor can not make blanket request for all invoices to support a given multi-item bill. However, if as part of the Dispute Resolution process a Payor can show that a given charge is on its face unreasonable, the Provider may then be required to produce the invoice to rebut the showing of unreasonableness.

- **Do I have to provide my invoices to the Payor? What happens if I do not provide my invoices after the Payor makes a timely request?**

    - The Payor can request from the Provider additional information, such as invoices, that it requires for review of the Provider's bill. However, the Payor must make its request within thirty (30) days from the date it receives the Provider's bill. *(See IDAPA 17.02.08.032.06.b)*

    - If the Provider falls to timely reply to the Payor's request, the period in which the Payor must pay or issue a Final Objection does not begin until the Provider's reply is received. *(See IDAPA 17.02.08.032.0 7. c)*

DOCUMENTATION

- **What forms are required when filing a Motion for Approval of Disputed**

Charges? To whom do I send the Motion?

- A Provider's Motion must be filed on the forms provided in the Commission's Judicial Rule Re: Disputes Between Providers and Payors. These forms include the Motion, Certificate of Mailing, and Appendix A. *(See Judicial Rule, pp. 6-8)*

- All forms and supporting documentation must be sent to the Industrial Commission and served upon the Payor within the timelines established in the regulations. "Served upon the Payor" means delivered to the Payor. Two common examples include hand delivery and delivery by U.S. mail, postage prepaid.

- **What types of evidence should I send to establish that my charge is "usual?"**

  - Examples of evidence include copies of billing statements, explanations of benefits, their fee schedules and/or affidavits from which the Commission can conclude that the charges are the same regardless of whether the injury or illness arose out of and in the course of the patient's employment or otherwise.

- **Do I need to submit evidence that my charge is "customary?"**

  - No, the Commission will determine whether the disputed charge is "customary" based on the Commission's compilation of Idaho Provider charges.

- **If the dispute concerns a Payor's failure to comply with timeliness what types of documentation should I submit with my Motion?**

  - The Provider should submit evidence that it complied with all applicable timeliness and that the Payor did not.

  - A Provider's Motion should also contain evidence that the Provider's charge is its "usual" charge, even if the only issue appears to be based on timeliness Commission staff will determine if the charge submitted in the Motion is "customary" as well.

- **What types of documentation do I submit when the medical service in dispute is not CPT-coded, or is unusual/exceptional?**

  - As with any other Motion, the Provider should submit evidence that the disputed charge is its "usual" charge for that service, or a similar service.

  - The Commission's "customary" charges database applies only to CPT-coded services, and may not contain sufficient data for unusual or exceptional services. When a service is not CPT-coded, or is unusual/exceptional, reasonableness is determined based on all relevant evidence available. The Provider should submit documentation relating to and/or supporting the reasonableness of its charge for the service *(See*

IDAPA II-.02.08.031.02.g. and h.)

- Further, for services not represented by CPT codes, the regulations indicate that relevant evidence specifically include invoices, industry standards and catalog prices. *(See IDAPA 17.02.08.031.02.g)*